health insurance for the disabled under social security

report of the advisory council on health insurance for the disabled 1969

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letter of transmittal

December 31, 1968

Honorable Wilbur J. Cohen
Secretary of Health, Education, and Welfare
Washington, D.C. 20201

Dear Mr. Secretary:

As required by section 140 of the Social Security Amendments of 1967, there is transmitted herewith the report of the Advisory Council on Health Insurance for the Disabled. The report, as directed by law, includes the Council's findings and recommendations with respect to the unmet need of the disabled for health insurance protection, the cost of providing such protection, and methods of financing such protection.

As Chairman, I want to express my deep appreciation for the work of the members of the Council, who gave unsparingly of their time, experience, and individual efforts. They have served with dedication and distinction.

On behalf of the Council I want to express appreciation also for the assistance of the staff, headed by Alvin M. David and Robert J. Myers. The Council's efforts were strengthened by the highly efficient service they gave us.

I trust that this report will be implemented so as to serve the needs of the chronically disabled and so as to supplement their cash benefits and allow them to live better lives.

Sincerely yours,

Henry H. Kessler, M.D.

Henry H. Kessler, M.D.
Chairman, Advisory Council
on Health Insurance for the Disabled

foreword

The Social Security Amendments of 1967 provide that an advisory council be appointed to study the question of extending Medicare to the disabled. The council was directed to determine whether the disabled have an unmet need for health insurance protection, and to examine the costs involved in providing this protection and the ways of financing it. During consideration of the 1967 social security amendments, the Congress gave attention to the possibility of extending Medicare benefits to social security disability beneficiaries, but decided to defer this matter, largely because of problems as to the most desirable method of financing Medicare protection for disability beneficiaries.

The Secretary of Health, Education, and Welfare appointed an Advisory Council on Health Insurance for the Disabled in June 1968. The Council held its first meeting on July 18 and 19, 1968, and met several other times during the remainder of the year. Between meetings the Council continued its study through consideration of extensive materials, including staff reports prepared by the Social Security Administration and letters and other documents from interested individuals and organizations.

membership of the council

*Morris Brand, M.D.
Medical Director, Sidney Hillman Health Center

James Brindle
President, Health Insurance Plan of Greater New York

James M. Gillen
Director of Personnel Research, General Motors Corporation

Henry H. Kessler, M.D., Ph.D., Chairman
Director, Kessler Institute for Rehabilitation

Juanita M. Kreps, Ph.D.
Professor of Economics, Duke University

William O. Kuhl, Ph.D.
Director, Research and Education, International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers, and Helpers

Leonard W. Larson, M.D.
Past President, American Medical Association

Daniel W. Pettengill, F.S.A.
Vice President, Group Division, Aetna Life and Casualty Company

Bert Seidman
Director, Department of Social Security, AFL-CIO

E. A. Vaughn
Vice President and Controller, Aluminum Company of America

Anthony G. Weinlein, Ph.D.
Executive Assistant to the General President, Service Employees International Union, AFL-CIO

E. B. Whitten
Executive Director, National Rehabilitation Association

Alonzo S. Yerby, M.D.
Professor and Head, Department of Health Services Administration, School of Public Health, Harvard University

*Deceased—replaced by William O. Kuhl

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introduction

As required by the Social Security Amendments of 1967, the Advisory Council on Health Insurance for the Disabled has examined the extent to which disabled persons in this country have an unmet need for health insurance, the costs involved in providing hospital and medical insurance for the disabled, and ways of financing this insurance.

The Council undertook to inquire into these matters in terms of a broader definition of disability than that used in determining a person's eligibility for cash disability benefits under social security; for that purpose, disability is defined as:

> inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

The Council examined data on persons identified as being disabled according to the definition used in the 1966 Survey of Disabled Adults.[1] That Survey defined disability as a limitation in the kind or amount of work (or housework) resulting from a chronic health condition or impairment lasting 3 or more months.

[1] The 1966 Survey of Disabled Adults was a national study of disability undertaken in the spring of 1966 by the Social Security Administration. The data for the study were collected by the Bureau of the Census.

Data from the 1966 Survey enabled the Council to compare the relative status of the estimated 18 million disabled individuals, classified according to the degree of their disability, in terms of income, labor force participation, utilization of health services, health expenditures, and health insurance status.[1] This Survey was based on a national area probability sample of 30,000 households, in which personal interviews were conducted with approximately 8,700 noninstitutionalized disabled adults under age 65. The study methods are discussed in Appendix B.

The 1966 Survey classified disabled individuals on the basis of their responses to questions about their ability to work. On this basis, 6 million individuals were classified as severely disabled (unable to work regularly or at all); 5 million were classified as occupationally disabled (able to work only part time or unable to perform the same work they had done before their disability began); and some 6.6 million individuals were classified as having secondary work limitations (limited in the kind or amount of work they could do as a result of their disability, but able to work regularly, full time, and at the same work they had done before their disability began).

Because of limitations in the data on the quality of health insurance coverage of both the disabled population and the population as a whole, the Council's consideration of the question of the "unmet need" of the disabled for health insurance was in terms of the extent to which the disabled have any form of private health insurance coverage, the types of health insurance that are available to them, and their ability to pay for such protection. The Council found that available data did not permit a detailed examination of the comprehensiveness of the health insurance coverage available to the disabled or the adequacy of the benefits paid under this coverage.[2]

[1] The 1966 Survey collected data with respect to people disabled 3 months or longer; however, data for those disabled 6 months or less (some 400,000 people) were not tabulated. The 18 million disabled adults also do not include an estimated 700,000 institutionalized severely disabled people. ("Institutionalized" is used to mean confined in mental, tuberculosis, or chronic disease hospitals, extended care facilities, VA hospitals, etc., but not to include patients in short-stay general hospitals). While the 1966 Survey of Disabled Adults included the institutionalized disabled, data from this part of the study are not yet available and no reliable data on the institutionalized disabled population are available from any other source.

[2] Of much help to the Council with respect to its consideration of the present status of group health insurance coverage and benefits were Health Insurance Association of America, *A Profile of Group Health Insurance in Force in the United States, December 31, 1966: A Survey of Group Health Insurance Policies by Level of Benefit Amounts* (Chicago: Health Insurance Association of America, 1967); Health Insurance Association of America, *A Comparison of Group Medical Care Insurance Benefits to Charges* (Chicago: Health Insurance Association of America, 1968).

Study data show that there is a direct relationship between the level of severity of disability, the incidence of health costs, and the extent of need for health insurance. It is readily apparent from 1966 Survey data that while persons with secondary disabilities used slightly more hospital and medical services than did the nondisabled population, they were comparable to the nondisabled in terms of labor force participation, employment status, and health insurance coverage.[1] While those with occupational disabilities were in a less advantageous position with respect to those criteria than were those with secondary impairments, they were significantly better off on all counts than were the severely disabled. Since employment status is the single most important determinant of health insurance coverage, it is significant that, in 1966, 72 percent of the occupationally disabled men were employed full time (as compared with 84 percent of the nondisabled men).

The occupationally disabled do, though, have a higher unemployment rate than the nondisabled population.[2] Thus, many among the occupationally disabled may have an unmet need for health insurance coverage—for example, persons who are unemployed for substantial periods of time or whose private insurance coverage is severely limited because of underwriting exclusions. On balance, the Council believes that, with the exception of the older occupationally disabled worker, the occupationally disabled individual stands a relatively good chance of becoming employed and having insurance coverage.

The Council has also given consideration to the fact that some persons who are able to carry on their regular work suffer from very serious disabling conditions and incur extremely heavy medical expenses. Such persons may have a substantial unmet need for health insurance protection or a need for some other means of meeting these expenses —for example, a person who has a chronic renal disease and who, although able to work full time, requires renal dialysis on a continuing basis. The Council recognizes that the question of the appropriate roles of the private sector, social insurance, and other public programs in meeting the expenses of catastrophic illness is a very significant one and one which deserves extensive consideration. The Council finds though that this area involves many broad and complex questions of social policy that go beyond the scope of this Council's assignment and therefore suggests that future advisory groups should consider the matter and, specifically, that the next Advisory Council on Social Security (to be appointed in 1969) should consider the role of social security in this area.

[1] Summary data on the occupationally disabled and those with secondary disabilities are presented in Appendix B.

[2] Seven percent of the occupationally disabled men were unemployed as compared with 3 percent of the nondisabled men.

The Council's examination of the unmet need of the severely disabled for health insurance included consideration of the appropriate roles of private insurance, social insurance and other public programs in filling the needs of the disabled for health care. As is described in Part I of this report, the Council found that because of the high costs involved in insuring the severely disabled and the difficulties inherent in extending group coverage to them, it is not realistic to expect that private insurance alone can adequately meet the needs of the long-term severely disabled. As to the question whether primary reliance should be placed on the social insurance mechanism or on other public programs for meeting the health care expenses of the severely disabled, the Council found that social insurance—the method used with a high degree of success in meeting the health care expenses of the aged—is much to be preferred. Specifically, 11 of the 12 members of the Council favor the extension of Medicare coverage to the disabled as a matter of principle, with some members differing with respect to the terms of coverage.

Part I of the report discusses the Council findings with respect to the unmet need of severely disabled persons for health insurance coverage, the costs involved in providing protection for this group, and the reasons why the Council believes the social insurance approach embodied in Medicare is the most feasible method of providing health insurance coverage. Part II of the report discusses the Council's recommendations as to eligibility for coverage under Medicare and how Medicare protection for the disabled should be financed. This part also includes a statement of the Council's views on vocational rehabilitation. Following Part II are minority views and recommendations.

summary of findings & recommendations

I. The Council has studied the need for and problems connected with health insurance for the disabled, and finds as follows:

1. Most severely disabled individuals have high health costs and low incomes. Disabled workers who qualify for social security disability benefits use seven times as much hospital care and three times as much physicians' services as does the entire population.[1,2] Hospital utilization is about 3¼ times as great for the disabled as for the aged; utilization of physicians' services is about 2½ times as great for the disabled as for the aged. The median income of disabled worker beneficiaries is less than half that of the nondisabled population.
2. The predominantly high health costs and relatively low incomes of the severely disabled make it unrealistic to expect private voluntary insurance alone to provide the great majority of them with comprehensive protection over the entire period of their disability. In 1966, only 46 percent of the disabled worker

[1] These figures and most of the data used in this report are based on the 1966 Survey of Disabled Adults, which is described in detail in Appendix B. Where data are taken from other sources, those sources will be indicated.
[2] "Entire population" includes noninstitutionalized adults under age 65.

beneficiaries under social security had some form of private health insurance; 40 percent had some degree of protection against both hospital costs and the cost of inpatient medical care.

3. It is appropriate, feasible, and desirable to use the social insurance approach to help finance the health costs of the disabled. Through the social insurance mechanism people can make contributions during their working years, when incomes are relatively high, and build protection against hospital and medical costs in the event they become disabled and unable to work. Reliance on the Nation's social insurance system will reduce the need for public assistance and permit Federal-State assistance programs to better fill their role as a backstop to private efforts and social insurance.

II. The Council proposes health insurance protection for the disabled on the following basis:

1. The existing hospital and medical insurance programs under title XVIII of the Social Security Act (Medicare) should be extended to those receiving social security monthly benefits on the basis of their disabilities.
2. Hospital and medical insurance benefits for the present disabled, as well as for those who become disabled in the future, should be financed by contributions from employees, employers, and the self-employed, with a contribution from Federal general revenues equal to one-half the cost of the program.
3. Instead of the 6-month waiting period required in present law for receipt of social security disability benefits, a 3-month waiting period should be required for hospital and medical insurance benefits. The requirement in the cash-benefit program that a disability must have lasted or be expected to last at least 12 months or to end in death should not apply in the case of Medicare benefits.
4. Older disabled workers should qualify for Medicare protection on the basis of less severe disability than is required under present law for eligibility for cash benefits. Insured workers aged 55 and over should be eligible for Medicare if they are so disabled that they can no longer engage in substantial gainful activity in their regular work or in any other work in which they have engaged with some regularity in the recent past.
5. Disabled people who qualify for Medicare protection but not for disability benefits should be eligible to receive vocational rehabilitation services financed by the social security program on the same basis as people who qualify for disability benefits.
6. The "level-cost" of the Council's recommendations is estimated at 0.80 percent of taxable payroll. In accordance with Recommendation No. 2 above, half of this cost, or 0.40 percent of taxable payroll, would be met from payroll contributions and the other half from general revenues.

part 1/the problem of health insurance protection for the disabled

The Council has considered the health care needs of the disabled, their present protection against the costs of health care, and alternative approaches to improving this protection. The findings of the Council are as follows:

1. Most severely disabled individuals have high health costs and low incomes.

Utilization of health services by persons who are severely disabled is substantially higher than is such utilization by the nondisabled. Disabled workers receiving cash benefits under the social security disability program use seven times as much hospital care in a year as does the entire population; their utilization of physicians' services is three times that of the entire population.[1] Utilization of health services by disabled worker beneficiaries is also higher than utilization of these services by the broader group of "severely disabled."[2] According to 1966 Survey data, hospital utilization under a health insurance program such as Medicare would be about 3¼ times as great for disabled worker beneficiaries as it is for the aged and utilization of physicians' services would be about 2½ times as great for disabled worker beneficiaries as for the aged. Comparing the

[1] "Entire population" includes noninstitutionalized adults under age 65.
[2] "Severely disabled" as defined in the 1966 Social Security Survey of Disabled Adults is discussed on page 43 of Appendix B.

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situation of the disabled worker beneficiaries with that of the aged, the Council found that in 1965 a higher proportion of the disabled than of the aged was hospitalized (29 percent and 14 percent, respectively). On the average, the disabled workers who were hospitalized stayed in the hospital almost twice as long as hospitalized aged persons (30 days and 16 days, respectively). Similarly, a higher proportion of disabled worker beneficiaries than of the aged had out-of-hospital physicians' visits (88 percent and 69 percent, respectively). Health care utilization—particularly hospital utilization—is indicative of health care costs. The health care costs of older people who were hospitalized were 10 times greater than for those who were not hospitalized.

While the health care expenses of the disabled worker beneficiaries are quite high in relation to those of the nondisabled population and to those of even the aged, the median income of social security disabled worker beneficiaries is less than half that of the nondisabled population. (The median income of these beneficiaries is slightly higher than that of severely disabled nonbeneficiaries, a fact attributable to their receipt of benefits.) On the basis of the Social Security Administration's poverty index, which takes into account family size, sex, and age of family members, half of the disabled worker beneficiaries were "poor or near poor" (annual income of less than $3,000 for two people, for example) and one-third of disabled worker beneficiaries were at or below the poverty level (annual income of less than $2,250 for two people, for example).[1]

While a sizeable proportion of the adult population taken as a whole is not insured for disability benefits under social security, a much smaller proportion of working people lacks such insured status. (And, in addition, disabled widows and widowers and adults disabled since childhood who get benefits based on their disabilities would have Medicare protection under the Council's recommendations.) Adults who will lack such protection are, then, primarily nonworking wives. Unlike disabled workers, these wives will have no reduction in income as a result of their disability. And, for many of them, private health insurance coverage as dependents, based on their husbands' work, will continue despite their becoming disabled.

2. **The predominantly high health costs and relatively low incomes of the severely disabled make it unrealistic to expect private voluntary insurance alone to provide the great majority of them with comprehensive protection over the entire period of their disability.**

[1] Office of Research and Statistics of the Social Security Administration, Division of Disability Studies, *Income of the Disabled* (preliminary report for the Advisory Council on Health Insurance for the Disabled).

With respect to health insurance coverage, the Council found that the severely disabled were in a very disadvantageous situation as compared to the total population and even as compared to the aged before Medicare. The Health Insurance Council estimates that at the end of 1966, 85 percent of the noninstitutionalized civilian population under age 65 had some protection against the cost of hospital care, 78 percent against surgical expenses, and 63 percent against in-hospital physicians' expenses. However, the 1966 Survey shows that in 1966 only 49 percent of the severely disabled had any health insurance and only 43 percent had some protection against the costs of both hospital care and inpatient medical care. Of the disabled worker beneficiaries, only 46 percent had some form of health insurance protection and 40 percent had some protection against both hospital costs and the cost of inpatient medical care. Before Medicare, 54 percent of the aged had some form of health insurance protection.[1]

The severely disabled person who is no longer attached to the labor force and who is no longer eligible for coverage under a group plan must, in most cases, rely on individually purchased policies or group conversion policies for protection against his health care costs. In general, coverage made available to the disabled on an individual basis—whether or not through conversion—is more expensive than coverage on a group basis and more expensive than individual coverage for nondisabled persons. Moreover, such coverage is likely also to be more expensive than the disabled person, who generally has suffered a significant reduction in income, can afford; or the benefits provided may be so limited that the coverage cannot be considered adequate.

The only way of providing adequate health insurance to the disabled at a moderate cost is on a group basis. Although the health insurance industry has tried to insure the disabled through improvements in employment-based group plans and through nonemployment-based groups, the Council finds that there is still a substantial unmet need. Most severely disabled people do not have comprehensive health insurance protection throughout their disability.

3. It is appropriate, feasible, and desirable to use the social insurance approach to help finance the health costs of the disabled.

The Council endorses using the social insurance mechanism embodied in the hospital insurance part of Medicare—the approach which has been used successfully in meeting the health expenses of the aged—as the primary means of meeting the health care expenses of the severely disabled. Through the social insurance mechanism people can make contributions during their working years, when incomes are relatively high, and build health insurance protection in the event they become totally disabled and unable to work.

[1] National Center for Health Statistics, *Health Insurance Coverage: United States, July 1962-June 1963,* (Series 10, No. 11), p. 17.

The social insurance approach seems the most feasible method of providing adequate health insurance protection for the disabled. Without a social insurance program, public assistance cannot be expected to fill the gaps in health insurance coverage left by private plans. And even if public assistance could meet the health care needs of the disabled, it is not a desirable method of meeting a problem so extensive in scope.

Social insurance has in it the potential whereby dependency and poverty can be prevented; public assistance, on the other hand, is a way to alleviate them after they occur. When seeking aid under an assistance program the individual must submit proof that he is unable to meet his basic needs; eligibility for social insurance requires only a record of work and contributions. Social security benefits are financed in part from contributions made by covered employees, and benefits are paid as an earned right and in a way that maintains the individual's dignity and privacy. Social insurance, then, is an extension of one's independence, while public assistance requires an admission of dependence. Moreover, social insurance, with benefits provided without a means test, encourages the individual to supplement those benefits with savings or additional protection.

The social security cash benefit program has done much to alleviate severe poverty among the disabled; for it to be truly effective in helping disabled people to maintain their independence, some protection must be offered against the high costs of health care associated with disability. There are no doubt many disabled persons who must seek public assistance because of the disastrous effects of their health costs. Health insurance protection through the social insurance mechanism would remedy most of these situations and would enable people to get the health care they need, without sacrifice of their independence. Such health insurance protection would also assure that some disabled persons who otherwise would not receive the care they need could get such care.

Financing of the major health care costs of the disabled through the social insurance mechanism would leave it possible for private plans to offer meaningful complementary coverage and might make it financially possible for many of the disabled either to purchase supplementary insurance or to meet residual health care expenses from their own resources. Public assistance programs would, of course, still be a necessary part of the health care system for the disabled, helping those persons with special needs and those not adequately protected by social insurance and private means combined. The Council believes, though, that, however well operated, the assistance approach—with eligibility based on a determination of individual financial need and with the amounts of payments related to the extent of that need—is basically incompatible with individual dignity, self-respect, and other accepted values. Assistance should serve only as a backstop where private efforts and social insurance plans cannot meet the need.

part 2/medicare protection for the disabled

1. **The existing hospital and medical insurance programs under title XVIII of the Social Security Act (Medicare) should be extended to those receiving social security monthly benefits on the basis of their disabilities.**

People who are now receiving social security benefits on the basis of a disability constitute a group of disabled in special need of Medicare protection. As has been noted, their utilization of health services is significantly greater than utilization by other segments of the disabled or nondisabled population. Their incomes are lower than those of other groups, to the extent that many of them are classified as "poor or near poor." Moreover, because of the long period during which these people have not worked—72 percent of disability beneficiaries have been on the rolls for at least 2 years, and 25 percent have been on the rolls for at least 6 years[1]—less than half of them have any health insurance coverage.

[1] Based on unpublished tabulations of the Office of Research and Statistics, Social Security Administration.

The Council considered the fact that the people already on the social security disability rolls would not have contributed specifically toward the cost of a health insurance program that would provide benefits for them. The Council's belief is that, as was done with respect to hospital insurance for the aged, protection should be extended to this group of people without any requirement as to further covered employment or social security contributions.

Special attention was focused on the present Medicare structure, under which the medical insurance part of the program is on a voluntary basis. It was decided that medical insurance as well as hospital insurance should be extended to present disability beneficiaries without any optional provision for election of medical insurance coverage. Moreover, disability beneficiaries should not be required to meet a new test of eligibility for such protection, either with respect to work requirements or with respect to the definition of disability.[1]

Extension of Medicare to the disabled would provide protection against the cost of inpatient hospital care, extended care, home health services, physicians' services, and other medical items and services.

The Council considered whether the benefits provided under Medicare would be appropriate to the needs of the disabled and concluded that while Medicare does not cover the cost of the long-term care which some of the disabled may need, it does cover the types of care needed by most of those who are disabled. In this connection the Council noted that the greater utilization of health services by the disabled raises a question of whether the benefits and benefit limitations under Medicare would be appropriate to the needs of the disabled. It concluded, however, that this question should be the subject of further study, with a view toward consideration of such changes in the Medicare program for the disabled as might be indicated.

[1] To be insured for disability protection a worker must, in general, have been in covered employment for at least 5 years in the 10- year period ending with his disablement, and must also have been in covered work for a period equal to about one-fourth of the time after 1950 (or age 21, if later) and up to the time he becomes disabled. However, a worker disabled after reaching age 24 and before age 31 is insured if he has been in covered work during at least half of the calendar quarters after he attained age 21; a worker disabled before age 24 must have been in covered work during at least half of the 12 calendar quarters preceding disablement. As indicated previously, disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

2. **Hospital and medical insurance benefits for the present disabled, as well as for those who become disabled in the future, should be financed by contributions from employees, employers, and the self-employed, with a contribution from Federal general revenues equal to one-half the cost of the program.**

The Council endorses the contributory social insurance method for financing both hospital and medical insurance protection for the disabled.

Under the present Medicare program, only the hospital insurance part of the program is financed through payroll contributions paid by employees, employers, and the self-employed. The medical insurance part of the program is financed on a current-premium basis, with enrollees paying monthly premiums equal to half the cost of the medical insurance program, and the other half being paid out of general revenues. The Council recognized that in the absence of special circumstances, it is both desirable and fair that all of those entitled to a specific benefit should be subject, to the extent possible, to the same provisions. On this basis, it might seem on first examination that, like the elderly who are already covered by Medicare, the disabled who elect to enroll in the medical insurance plan should pay monthly premiums equal to half the cost of the protection they receive. However, since the per capita cost of providing medical insurance to the disabled is estimated to be three times the cost of insuring the aged, inclusion of the disabled in the medical insurance plan on a current-premium basis raises such difficult problems that inclusion on this basis would clearly be inappropriate and indeed self-defeating in meeting the health needs of the disabled. If the disabled were required to pay half the cost of this protection, many of those who most need the protection might not be able to afford the high monthly premium. In addition some of the disabled—those in comparatively good health—might be able to meet their insurance needs at lower costs elsewhere, leaving only those who are high-cost risks in the plan. This would, of course, result in even higher premiums, which would tend to reduce enrollment still further. The Council found that it would be inequitable to require aged medical insurance enrollees to bear the burden of the added cost of insuring the disabled. On the other hand, while the Federal Government might contribute more than half of the costs of the medical insurance for the disabled, while continuing to match half of the costs for the aged, serious questions could be expected about the appropriateness of this approach.

In the Council's judgment, the preferred solution to the problem is for both medical and hospital insurance for the disabled to be financed through the contributory social insurance system. The Council considers it desirable and appropriate that the costs of hospital and medical care insurance for the disabled be partly financed through contributions paid by the entire population at risk—the working population—and their employers, together with a Government contribution equal to half the cost of the protection.

This method of financing offers not only a broad financial base but also a mechanism through which workers can pay in advance toward the cost of the health insurance that they will have should they become disabled.

The Council regards the proposed cost allocation as the most satisfactory in view of the greater need of the disabled for this protection and the higher cost involved in providing the protection for them. The Council notes that sharing by general revenues of social insurance program costs is not uncommon among foreign social insurance systems. It believes also that the allocation is reasonable in view of the fact that under present law general revenues are used to pay half the cost of medical insurance for the aged and all of the cost of providing hospital insurance protection for the "transitionally insured"—older people who are not insured for cash benefits and who qualify for hospital insurance under a special transitional provision.

Financing medical insurance for the disabled, as well as hospital insurance, through the social security system has several additional advantages. First, if the social security system is used—rather than current-premium financing—protection could be made available to the disabled on a retroactive basis. In the opinion of the Council, this would be especially important, owing to the fact that in many cases a determination of disability will be made some time after a person is first eligible for Medicare. Availability of retroactive benefits would assure equal treatment of beneficiaries instead of differential treatment based on the accident of the length of time needed for the administrative procedure of determining eligibility. Under the hospital insurance part of the present Medicare program, eligibility provisions allow the earliest possible coverage, including up to 12 months retroactive coverage (from the date of a person's application); under the medical insurance part of the program, because of the current-premium nature of the financing, it is not practical to have retroactive coverage, and none is provided. The Council does not believe there is any way in which medical insurance could be made available to the disabled over even a limited retroactive period if the program were financed on a voluntary basis.

The Council also notes that financing medical insurance for the disabled through the contributory social security system would result in administrative savings; the need for premium billing, collections, and recordkeeping, initial and general enrollment periods, and various determinations concerning the time at which coverage starts and is terminated would be eliminated for this group. The greater simplicity of the program should also lead to greater understanding on the part of disabled beneficiaries of their rights under the program.

3. **Instead of the 6-month waiting period required in present law for receipt of social security disability benefits, a 3-month waiting period should be required for hospital and medical insurance benefits. The requirement in the cash-benefit program that a disability must have lasted or be expected to last for at least 12 months or to end in death should not apply in the case of Medicare benefits.**

A waiting period of 6 full calendar months (as now required for cash disability benefits [1]) would be inappropriate for the purposes of Medicare protection. A waiting period this long would withhold protection when medical care costs press most urgently and when the psychological attitude of the disabled worker is crucial.

A waiting period of 3 full calendar months, on the other hand, would be reasonable and appropriate for Medicare purposes. Private insurance based on past employment frequently covers hospital and medical costs during the first 3 months after disablement. After 3 months of total disability, however, many severely disabled persons have lost their insurance coverage. Others may soon lose protection if they do not convert their group coverage to individual coverage, which they may not be able to afford. A 3-month waiting period would ensure continuity of protection for many disabled workers.

Making Medicare protection available beginning after the third month of disability (rather than after the sixth month as is the case with social security cash benefits) should contribute to the early restoration of workers to gainful employment and thus should benefit the individual, his community, and the Nation. The Council anticipates that the earlier coverage would also result in savings to the social security cash-benefit program. For example, with prompt treatment some disabled workers who might otherwise become cash disability beneficiaries might recover before qualifying for cash disability benefits. For others, medical restorative services started early in the course of disability can be expected to shorten the period of disability and entitlement to cash disability benefits.

In view of the importance of early availability of treatment and services, the Council evaluated waiting periods shorter than 3 months for Medicare purposes. (Some members who supported a 3-month waiting period actually favored a much shorter waiting period requirement.) The Council took into account that, in addition to the increased cost, serious administrative problems would be encountered with a shorter waiting period. Reliable medical evidence in many cases would not yet be available. It would be quite difficult in the general case to reach reliable decisions within a period of less than 3 months as to whether or not the impairment meets the

[1] Disability insurance benefits cannot begin until after the worker has been disabled throughout a waiting period of 6 consecutive calendar months. Thus, if a worker becomes disabled on, say, January 10, his waiting period extends from February 1 through July 31; his first benefit check would be for August, and would be payable eary in September. No waiting period is required for the worker who again becomes disabled within 5 years after a previous qualifying disability ended. Disabled widows and widowers must also serve a 6-month waiting period. Adult sons or daughters disabled since before age 18 are not required to serve a waiting period. However, benefits based on childhood disability are not payable until attainment of age 18, and most of these individuals became disabled at or soon after birth.

required level of severity. The Council believes that a thorough exploration and study of the question of a waiting period shorter than 3 months and of possible solutions to these complex administrative problems is warranted.

The Council could find no justification for adopting in the Medicare program the present requirement under the cash-benefit program that total disability must have lasted or be expected to last 12 months or to end in death. Such a requirement for Medicare purposes seems unnecessary and undesirable. The worker who has been totally disabled throughout 3 calendar months may have been without earnings for a substantial period. The problem of meeting day-to-day living expenses is compounded by high medical care costs that can generally be expected to continue for some time.

It is clear that proper administration of the recommended program would be greatly hampered if the program included a requirement that the disability must be expected to last a specified length of time that is longer than the waiting period. Many workers who are totally disabled for as long as 3 months will continue to be disabled much longer. But in many cases evidence sufficient for a reliable prognosis is not available after only 3 months of disability. Providing Medicare protection as of the end of the waiting period without regard to how much longer the disability might last would facilitate prompt determinations of eligibility and facilitate administration in general.

In order that the objectives of the shorter waiting period may be accomplished, disabled persons, as well as providers of services, should know in as many cases as possible by the beginning of the fourth calendar month of disability whether or not they will qualify for Medicare protection. Retroactive benefits obviously have relatively limited value in assuring early treatment of disabilities. This is a major reason for the Council's recommendation that the requirement that disability must have lasted or be expected to last at least 12 months be made inapplicable for purposes of Medicare protection. If such a requirement were retained, it would be virtually impossible in many cases to make prompt and reliable decisions and to provide early notification to the applicant. (The need for timely decisions and notifications also contributed to the Council's decision in favor of a 3-month waiting period rather than a shorter one.)

The Council believes that people who become eligible for social security cash benefits based on their own disabilities should have eligibility for Medicare protection continued for a period beyond the time they are eligible for cash benefits. (In general, cash disability benefits are continued through a trial-work period of 9 months and for a period of 2 months after the month in which the beneficiary no longer meets the social security definition of disability.) The Council recommends that Medicare protection be continued for 6 months after the last month for which the beneficiary is entitled to monthly cash benefits on the basis of his disability. This recommendation takes account of several factors. Workers who have had severe long-term disabilities may have difficulty in obtaining private insurance

coverage when they recover. Many private insurance policies impose waiting periods with respect to pre-existing conditions. Also, some individuals who leave the disability rolls become disabled again within a short period of time. The Council believes that people in this latter category should be eligible for Medicare in the first full calendar month of their subsequent disability if this subsequent disability occurs within 60 months after they were last entitled to cash disability benefits.[1]

For people who are not eligible for cash disability benefits but who are eligible for Medicare under the Council's proposal, Medicare protection should continue for 2 months following the month in which the individual ceases to meet the social security definition of disability. The 2-month extension of Medicare would take account of the fact that these people, like social security cash beneficiaries, may not be able to obtain private insurance protection immediately after they recover from their disabilities. At the same time, it recognizes that some of these individuals will have relatively short-term disabilities and will have been entitled to Medicare for as little as 1 month when they recover.

4. **Older disabled workers should qualify for Medicare protection on the basis of less severe disability than is required under present law for eligibility for cash benefits. Insured workers aged 55 and over should be eligible for Medicare if they are so disabled that they can no longer engage in substantial gainful activity in their regular work or in any other work in which they have engaged with some regularity in the recent past.**

The Council was concerned about the situation of the older handicapped worker who—even though he has a serious impairment—does not meet the present social security definition of disability applicable for cash benefits. Under the present definition (except for blind workers at age 55 [2]) a person is disabled only if he is unable to engage in *any* substantial gainful activity. If this test of disability were applied for Medicare purposes to all workers regardless of age, many older workers who because of their disabilities can no longer perform their usual work would be denied protection. Many older workers cannot meet the present definition because they have the residual capacity to do some work.

[1] This would parallel the provision in present law under which the 6-month waiting period requirement is waived in those cases where an individual becomes disabled again within 5 years after his previous entitlement to disability benefits had ended. Where subsequent disability occurs after this 5-year period, the disabled individual must serve a 6-month waiting period.

[2] Blind workers aged 55 or older are "disabled" if they are unable because of this handicap to engage in substantial gainful activity requiring skills or abilities comparable to those required in any gainful activity in whch they have previously engaged with some regularity and over a substantial period of time.

The Council's proposal that older disabled workers should qualify for Medicare protection on the basis of a less severe disability than is required under present law for cash benefits reflects the following considerations.

An impairment of a given level of severity generally has a greater effect on the older worker than on a younger worker, and a younger disabled worker stands a much better chance to recover and be retrained to engage in another type of work. Many employers are likely to prefer a nondisabled worker. The employer is also more likely to hire a younger disabled worker rather than an older disabled worker. Even those older workers who are fortunate enough to engage in work are likely to be working only part time or intermittently and at an earnings level significantly below their usual level before disability.

It can be expected that the older disabled worker will very likely incur substantial medical care costs when he has lost his regular job and is without earnings. In addition, if older disabled workers do not have health insurance protection through employment, they will generally not be able to purchase (or even to afford) private health insurance.

The Council therefore concluded that older disabled workers should qualify for Medicare protection if they are unable to engage in substantial gainful activity in their regular work or in any other work in which they had engaged with some regularity in the recent past.

In general, the conditions under which Medicare protection is terminated for other disabled persons should also apply in the case of workers age 55 and over who would be covered under the recommended special definition of disability. Thus, for those who may later qualify for cash benefits based on disability, Medicare protection would be terminated 6 months after the termination of cash benefits. For those individuals who do not later qualify for cash benefits based on disability, Medicare protection would end 2 months after the month in which the disability ended.

It may be desirable, however, to suspend Medicare protection when an older handicapped worker is actually doing substantial gainful work, whether or not this is his regular work. If he is working he may have health insurance through this employment. The worker's Medicare protection would begin again with the first month in which he is no longer performing substantial gainful work.

The Council believes that, after Medicare protection is extended to the disabled and experience under its provisions is acquired, a study in depth should be made to determine the adequacy of these provisions in meeting the medical care needs of older handicapped workers.

The Council believes that it would also be desirable to provide cash benefits for such older disabled workers, and to provide cash benefits for all disabled workers under the changes proposed in Recommendation No. 3 (involving reduction of the waiting period), but the Council recognizes that it was not charged with responsibility for recommending modification of the disability cash benefit

provisions and therefore has not made any recommendations concerning the cash benefit program.

5. **Disabled people who qualify for Medicare protection but not for disability benefits should be eligible to receive vocational rehabilitation services financed by the social security program on the same basis as people who qualify for disability benefits.**

A major objective of the social security disability provisions is to promote vocational rehabilitation of the disabled. All applicants for social security benefits based on their own disabilities are referred to State vocational rehabilitation agencies for vocational rehabilitation services so that as many of them as possible may be restored to productive activity. The 1965 social security amendments included provisions designed to enable more disabled beneficiaries to receive vocational rehabilitation services. The amendments provided for reimbursement from the Federal Disability Insurance Trust Fund and the Federal Old-Age and Survivors Insurance Trust Fund to State vocational rehabilitation agencies for the cost of rehabilitation services furnished to certain social security disability beneficiaries. For reimbursement to be made from the trust funds, there must be a reasonable expectation that the rehabilitation services provided will result in restoration of the individual to productive activity. The provision was enacted on the assumption that the money paid from the trust funds for rehabilitation would result in no net cost to the trust funds—that is, the savings in benefits that would otherwise have to be paid and the social security contributions paid on the earnings of those successfully returned to work would equal or exceed the cost of rehabilitation services. The total amount of reimbursement in any year may not exceed 1 percent of the total amount paid in benefits based on disability in the previous fiscal year.[1]

Protecting the disabled under Medicare against the cost of health care services will contribute much to this rehabilitation objective. The contribution would be even greater if disabled persons who qualify for Medicare protection were eligible to receive vocational rehabilitation services financed from the trust funds even though they do not become eligible for disability benefits. Services such as retraining and placement and vocational guidance and counseling are not covered by existing Medicare provisions and could help many disabled persons to an early and successful return to work. The Council therefore concluded that disabled persons qualifying for only Medicare protection (i.e., not for cash benefits) should also be eligible to receive vocational rehabilitation services, the cost of which would be reimbursed from the trust funds, along the lines of the existing

[1] In fiscal year 1968, the total funds available for rehabilitation services through reimbursement from the social security trust funds amounted to $16,000,000, and about $18,300,000 is available for fiscal year 1969. For fiscal year 1968, over 5,500 beneficiaries who have received rehabilitation services paid for by social security trust funds have been successfully rehabilitated—that is, have been returned to gainful work.

provisions for disabled beneficiaries. Financing would thus be provided for services that are furnished under a State plan for vocational rehabilitation services if there is an expectation that the services provided would result in savings to the trust funds.

The Council recognizes that the total amount of reimbursement in a year—now limited to 1 percent of the total amount paid in benefits based on disability in the previous fiscal year—would not be sufficient to cover the cost of services furnished people who qualify for Medicare but not for cash benefit protection. (In fact, it appears to the Council that in the near future there will probably not be sufficient funds available from the trust funds to cover services for all of the cash disability beneficiaries who might qualify under the reimbursement provisions.) The Council recommends that the total annual amount available for reimbursement for vocational rehabilitation services be calculated as 1 percent of the total amount of benefits paid to the disabled—monthly cash benefits and Medicare benefits. This would provide an amount at least twice as large as is presently available for rehabilitation services.

The major part of the eventual savings to the trust funds resulting from vocational services furnished disabled persons can be expected to accrue to the Federal Disability Insurance Trust Fund. It thus seems appropriate that the major part of the costs of such reimbursement, including the costs for people who do not qualify for cash disability benefits, be financed from that trust fund. It also appears that some recognition should be given in the financing provisions to savings to the separate trust fund established for the Medicare-for-the-disabled program [1] because some people will be restored to productive life earlier and thus will not remain eligible for Medicare protection for as long as they might have without the rehabilitation services. The Council recommends that the Secretary of Health, Education, and Welfare be authorized to prescribe such methods and procedures as he may deem appropriate for determining the extent to which such reimbursement costs should be charged to the separate trust fund established for Medicare for the disabled.

6. **The "level-cost" of the Council's recommendations is estimated at 0.80 percent of taxable payroll. In accordance with Recommendation No. 2 above, half of this cost, or 0.40 percent of taxable payroll, would be met from payroll contributions and the other half from general revenues.**

Under the present $7,800 earnings base, the proposed Medicare program for the disabled would have a "level-cost" of 0.80 percent of taxable payroll—0.57 percent for the hospital insurance part of the program and 0.23 percent for medical insurance. Under the recommendations of the Council, half of the cost would be met from general revenues, so that the remaining cost to be financed by the contributions of workers and employers represents a level-cost of 0.40 percent of taxable payroll.

[1] Referred to under Recommendation No. 6 below.

About 2½ million people—disabled workers, adults disabled since childhood, and disabled widows and dependent widowers—would be protected under the proposed program in the first year of operation, assuming that to be 1970. Under the proposal, about $2,300 million—$1,520 million for hospital insurance and $780 million for medical insurance—would be paid in the first year of operation for benefits and administrative expenses.

A separate trust fund should be established for the proposed program. Into this trust fund would go the contributions of employees, employers, the self-employed, and the contributions from general revenues, and from it would be paid the benefits and applicable administrative expenses. Any available monies would be invested in the same manner as is now done for the existing social security trust funds, and the investment earnings would be available to assist in the financing of the program.

Appendix A, "Actuarial Report on Cost Estimates," gives further details on the concept of the "level-cost" as it is applicable to the financing of this program. This appendix also presents cost estimates for various alternative proposals considered by the Council.

minority views and recommendations presented by mr. gillen/dr. larson/ mr. pettengill & mr. vaughn

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The aforementioned members of the Council respectively disagree with recommendations of the majority of the Council. Mr. Gillen, Dr. Larson, and Mr. Vaughn recommend instead:

(1) that the Medicare program be extended only to OASDI cash disability beneficiaries with health insurance benefits payable commencing on the 1st of the month following completion of 12 full calendar months of continuous disability, as disability is currently defined for cash benefits. In no event, however, would benefits commence more than 12 months prior to the date the individual files proper application for Medicare coverage with the Social Security Administration.

(2) that the supplementary medical insurance for such disabled, as well as the hospital insurance, be automatic rather than voluntary, with the entire cost of this extension to be handled through a separate trust fund and be financed by a payroll tax shared equally by employers and employees with the self-employed paying 75 percent of the combined tax on employers and employees. The "level-cost" of this approach is estimated at 0.45 percent of taxable payroll.

The rationale in support of these substitute recommendations is outlined below. Fundamental to this rationale is the belief that any

governmental program should cover only the long-term disabled and leave the needs of the short-term disabled (as well as certain of the long-term disabled) to be covered by the private sector or by title XIX in the case of the needy.

It should be noted that the Council was appointed June 29, 1968, and held its first meeting on July 18-19, 1968. Thus, less than 6 months were available to the Council for studying a complex topic and for making recommendations of great import to this Nation.

The Council found no definitive data on the extent to which the medical needs of the disabled were currently unmet. Among the voluminous documents presented to the Council there were suggestions that more rehabilitative work could and presumably should be done, but there was no way of measuring the degree to which an extension of Medicare to the disabled would stimulate greater use of rehabilitation or the portion of the cost thereof that would be paid by the Medicare benefits. Thus, the Council focused its attention primarily on the methods of financing existing medical care rather than on providing additional care.

The Council found essentially no data on how the disabled are currently financing the substantial medical care the data show they do receive. It was noted, however, that private health insurance plays a significant role in the early months of disability for most of the disabled, and, for some, continues to play an important role even after disability has lasted several years.

The Council reviewed both published and unpublished data from the 1966 Social Security Survey of the Disabled. As indicated in the report, this survey was based on personal interviews with approximately 8,700 noninstitutionalized adults under age 65 who considered themselves to have a work limitation due to a chronic health condition or impairment that had lasted for at least 3 months. Human memory being what it is, statistics based on such personal interviews are merely indicative rather than precise. The Chief Actuary of the Social Security Administration pointed out to the Council that apparenty there had been serious underreporting in a similar survey of the aged which was made when the Medicare program for the aged was under consideration and that, as a result, the Government's original cost estimates for that program had been considerably underestimated. The Chief Actuary stated that in making estimates of the cost of extending Medicare to the disabled, he had endeavored to compensate for possible underreporting in the 1966 Social Security Survey of the Disabled.

In addition to its inherent weaknesses, the 1966 Survey's usefulness to the Council was further limited by the fact that data on medical expenses were not tabulated by the approximate length of time between the date disability commenced and the date the service was rendered, and by the fact that neither the existence of insurance nor the lapse thereof was tabulated by the applicable length of time the individual had been disabled. Thus, it should be noted that the 1966 Survey estimated that 48.8 percent of the "severely disabled" population had health insurance coverage may be understated and, in

any event, indicates insurance coverage status not at the date of disablement but at the date of the interview which occurred anywhere from 6 months to many years thereafter. Indeed, the respondents may have been disabled an average of 5 years at the time of the interview.

The Council was advised that some employers voluntarily continue group medical expense benefits as long as the disability lasts or until the individual becomes eligible for Medicare, whichever occurs first. Contract negotiations between employers in the automobile industry and the United Automobile Workers have resulted in employer-paid protection being continued for a period equal to the individual's seniority at the onset of disability, or for his lifetime if retired for age or disability.

Also, the Council was advised by some of its members that insurance company group medical expense contracts generally provide that insurance may be continued during a period of disability.

Furthermore, these contracts provide that, in the event insurance is discontinued during disability, the benefits will nevertheless continue to be payable after the date insurance is terminated for at least an additional 90 days, and up to 365 days in the case of major medical benefits. Thus, relatively few disabled workers under age 65 are likely to lose protection during the first year of their disability and the Health Insurance Council estimated that, as of December 31, 1967, at least 87 percent had private hospital expense insurance at the onset of disability.

The number of disabled persons under age 65 who will ultimately be without some medical expense coverage appears to be gradually decreasing. Yet, there is little doubt that an individual, who has become totally and presumably permanently disabled and has lost his insurance, has difficulty in obtaining new coverage at standard rates. Indeed, a few cannot obtain coverage at any rate. Hence, the alternative recomendations that have been made.

In conclusion, the extension of Medicare to the short-term disabled as proposed by the majority of the Council should not be adopted for the following reasons:

1. **It would duplicate much of the existing private medical expense insurance.**

a. To the extent that private insurance did not adjust to avoid this duplication, a severe overinsurance problem could arise.

b. To the extent that private insurance withdrew from this field, both the new Medicare beneficiaries and the providers of medical care might have to contend with a significant initial period of uncertainty as to whether the beneficiary's expenses would be covered by Medicare. In this connection, Table 5 of the HEW report entitled "Social Security Disability Applicant Statistics of 1965" indicates that of all those approved for cash disability benefits in 1965, only 20.8 percent were approved in the same year as they were disabled and only 50.8 percent were approved in the year following the year in which disability commenced.

2. **It would provide 3 to 5 months' temporary insurance coverage each year to at least 600,000 persons whose disabilities would last long enough to qualify for Medicare coverage but not long enough to qualify for cash disability benefits and for whom there is no evidence of a significant unmet need.**

This 600,000 is a figure about 1.7 times the number of workers who would newly qualify each year for cash disability benefits. The resulting increased administrative burden is obviously going to be very expensive overhead to add to the direct costs and seems unwarranted in the face of a lack of evidence of an unmet need for these 600,000 people.

3. **It would introduce general revenue financing for a strictly social insurance benefit and hence could undermine the sound self-supporting policy on which such benefits have been based in the United States.**

The Council did agree that the Medicare program would suffer a considerable degree of antiselection by the disabled beneficiaries if the supplementary medical insurance benefits (part B) were to be offered to them on a voluntary basis with a 50-50 percentage split of the cost between the disabled and the Government, as is now the case with respect to the aged. Thus, any extension of part B to any class or classes of the disabled as currently defined should be on an automatic enrollment and noncontributory basis. This would then make part B analogous to part A. Thus it would seem to require 100 percent payroll tax financing, the same as applies to part A and to all the other true social insurance benefits in the system. There would appear to be neither need nor justification for any general revenue financing once enrollment is made automatic.

Mr. Pettengill concurs with the rationale developed by Mr. Gillen, Dr. Larson and Mr. Vaughn and finds their substitute recommendations both logical and practical if the Federal Government is to enter the field of medical expense insurance for the disabled on a unilateral basis. However, Mr. Pettengill believes that the disabled can best be assisted in securing medical expense insurance through a partnership of private enterprise and government. Specifically, he recommends in lieu of any extension of Medicare, that the Federal Government assure the availability of adequate private medical expense insurance by having each State require at least certain carriers to offer specified coverage at a specified premium to all the uninsurables residing in that State. Such coverage would be designed so as not to duplicate any other coverage the individual might otherwise acquire and would be reinsured by all carriers licensed in the State with governmental subsidy of the premiums to keep the cost of such coverage within the financial reach of most of the uninsurables.

Mr. Pettengill believes that the advantages of his suggested approach are:

(1) that there would be no disruption of the thousands of private employee benefit programs now in existence;

(2) that the cost should be less since only those unable to secure adequate medical expense insurance would be involved;

(3) that all the disabled in need of insurance protection would be benefited rather than just those who have insured status under the social security program and cannot work (it is estimated that about 40 percent of the adult population under age 65 currently lacks insured status under the disability insurance part of the social security program); and

(4) that the disabled would not be required to drop this insurance by reason of returning to work and hence might be more encouraged to try to return to work, which would be good for all concerned.

appendix a
actuarial report on cost estimates

Prepared by Robert J. Myers, Chief Actuary, Social Security Administration

This appendix presents further details on the actuarial cost estimates for the recommendations of the Council and for a number of alternative proposals which were considered by the Council.

The measurement of long-range costs, consideration of which is essential for a program of this type, is accomplished by the use of the concept of level-costs. The term "level-cost" is defined as the present value of future disbursements, at a prescribed interest rate, over the 25-year period covered by the cost estimate, plus the present value of a fund at the end of the period equal to 1 year's disbursements then, divided by the present value of future taxable payrolls. Level-costs are thus expressed as percentages of taxable payroll. The term "present value" connotes discounting at interest.[1] It can be said, therefore, that a contribution rate equal to the level-cost of the benefit payments and the administrative expenses will be sufficient to support the particular program under consideration.

[1] As an example, the present value of $1,000 due in 10 years, taking into account 3 percent interest, is $744. The present value of a series of amounts payable at various future dates is the sum of the present values of each of the amounts.

Medicare benefit payments for the proposed categories that would be covered by the recommendations of the Council will increase for many years—not only in terms of dollars, but also as a percentage of taxable payroll. Estimates covering a 25-year future period are needed, therefore, to indicate the extent to which the cost will increase and to determine tax rates adequate to maintain the system on an actuarially-sound basis. Over this period, the benefit cost will rise, not only because of the increasing number of persons eligible for benefits, but more importantly also because of the likely increase in health care costs per unit of service. The latter have increased in the past significantly more rapidly than the general earnings level, and it is likely that this trend will continue for some years.

The cost estimates for the Medicare program recommended by the Council assume both rising general earnings levels and rising medical costs in the future. At the same time, it is assumed that the maximum taxable earnings base of $7,800 remains unchanged over the 25-year period considered. This same approach is used in the cost estimates for the existing hospital insurance program. Increases in the general earnings level, when accompanied by parallel (or greater) increases in medical costs, result in higher costs relative to taxable payroll than if the earnings base were assumed to be increased from time to time to keep up to date with the general earnings level. The reason for this result is that, under these conditions, medical costs rise more rapidly than covered earnings, whose increase is "dampened" by the effect of the earnings base. Thus, the use of the assumption of no change in the earnings base is of a conservative nature and provides a margin of safety. If the earnings base is actually kept up to date in the future, and if the experience follows the various assumptions made, then the cost (measured against taxable payroll) would be significantly lower than shown by these estimates—perhaps by as much as 15 percent for the level-cost.

Based on data from the 1966 Survey of Disabled Adults, rough estimates were derived of the hospital and medical services utilization of disabled beneficiaries as related to the corresponding utilization of persons aged 65 and over. On the whole, the hospital utilization of the disabled was about 3¼ times as high as for the aged, while the utilization of physician services was about 2½ times as high; this was taken into account in the cost estimates for the recommendations of the Council.

Also considered were the resulting effects of the various cost-sharing provisions and the likely differences in utilization for any additional disabled beneficiaries resulting from any reduction in the waiting period from the 6 months now applicable for cash benefits and resulting from any change in the definition of disability. It was assumed that those affected by a reduced waiting period would have significantly higher utilization during the time involved in such a reduced period and, conversely, that a less restricted definition of disability would involve lower utilization for the additional beneficiaries than for those under the present strict definition. Quite naturally, for any alternative involving a longer waiting period than 6

months, it was assumed that the utilization would be lower than would result under a 6-month waiting period.

The accompanying table presents actuarial cost data both for the proposal recommended by the Council and for a number of alternatives considered by the Council. It should be kept in mind that there are significant differences among the several definitions of disability for which figures are given. In brief, these definitions of disability can be summarized as follows:

(1) *Present definition of disability*—Inability because of total disability to engage in any substantial gainful activity.

(2) *Present definition of disability used for blind persons aged 55 and over*—Inability because of total disability to engage in substantial gainful activity requiring any skills or abilities comparable to those required in any gainful activity in which he had previously engaged with some regularity over a substantial period of time.

(3) *"Partial" occupational definition*—Inability because of total disability to engage in substantial gainful activity in his regular work or in any other work in which he had engaged with some regularity in the recent past.

(4) *"True" occupational definition*—Inability because of total disability to effectively perform his regular work.

The plan recommended by the Advisory Council has an estimated level-cost of 0.80 percent of taxable payroll. Half of this cost would, under the recommendations, be met from general revenues, and the remainder would come from payroll taxes. The payments from general revenues would be equal to, and payable at the same time as, the employer and worker taxes. They would be received by the trust fund which is specially established for the new program.

The financing, according to the estimates, could be accomplished by a level contribution rate on employers and employees combined amounting to 0.4 percent (and 0.2 percent from the self-employed). Alternatively, this rate could begin at 0.35 percent and be gradually graded up to an eventual 0.45 or 0.50 percent. A lower initial rate than 0.35 percent would not be possible, because the estimated first-year cost is almost 0.60 percent of taxable payroll (which would require an employer-employee contribution rate of 0.30 percent), and there would also have to be an allowance for contingencies and building up a moderate fund.

cost estimates for medicare for disabled insured persons for various concepts of disability.

Numbers of people and amounts of payments in millions

Concepts				1970 Data		
Waiting Period [a]	1-year Prognosis of Duration	Level-Cost [b] HI	Level-Cost [b] SMI	Number of Beneficiaries Protected [c]	Benefits Payments [d] HI	Benefits Payments [d] SMI
Present Definition of Disability						
24 months	Yes	.23%	.09%	1.05	$ 610	$ 310
12 months	Yes	.32	.13	1.31	850	440
*6 months	Yes	.38	.15	1.69	1,000	520
6 months	No	.39	.15	1.73	1,020	530
3 months	No	.47	.19	1.96	1,240	640
1 month	No	.83	.34	2.71	2,190	1,130
30 days	No	.95	.39	2.95	2,500	1,290
Present Definition before Age 55, Present "Blind" Definition after Age 55						
3 months	No	.54%	.22%	2.23	$1,420	$ 730
1 month	No	.96	.39	3.12	2,520	1,300
30 days	No	1.11	.45	3.50	2,920	1,510
Present Definition before Age 55, "Partial" Occupational Definition after Age 55						
**3 months	No	.57%	.23%	2.54	$1,520	$ 780
Present Definition before Age 55, "True" Occupational Definition after Age 55						
6 months	Yes	.49%	.19%	2.63	$1,280	$ 670
6 months	No	.50	.20	2.69	1,300	680
3 months	No	.68	.27	3.12	1,790	920
1 month	No	1.28	.52	4.17	3,370	1,740
30 days	No	1.57	.64	4.57	4,150	2,140

* Definition for insured workers for cash benefits of present law.
** Recommendation of Advisory Council.
[a] Waiting periods stated in months are based on *full* calendar months.
[b] As percentages of taxable payroll (at $7,800 base).
[c] Average number during year.
[d] Including administrative expenses.
Note: See text for description of various definitions of disability.

appendix b
1966 social security survey of disabled adults

Prepared by the Division of Disability Studies, Office of Research and Statistics, Social Security Administration

More than one-sixth of the civilian noninstitutional population of working age were limited in their ability to work because of a chronic health condition or impairment in 1966. A major proportion of the waste of manpower through involuntary nonparticipation in the labor force, unemployment, and underemployment may be attributed to disability. Public income-support programs provided income for a majority of the severely disabled, but two-fifths of the severely disabled men are neither employed nor receiving wage-replacement income. Although three-fifths of the severely disabled women received no public support or wage-replacement income, they are as a group less dependent than men on earnings and earnings' replacement programs.

Disability causes substantial losses of earnings and family income. Public programs designed to offset the wage losses of disability paid out more than $8 billion in cash benefits and assistance to the disabled and their dependents in 1966. Wage-replacement benefits provide only a fraction of the income available from earnings, however, and they are in many cases, below minimum budgetary standards of adequacy. For the disabled individual, his family, and society, disability is a social and economic problem of major dimensions.

A national survey of disabled adults was conducted by the Social Security Administration to examine the major economic, occupational, and other social consequences of disability and to evaluate the social insurance provisions for disability.

The following papers describe the methods and procedures used in the 1966 Survey of Disabled Adults and the data presented to the Advisory Council on Health Insurance for the Disabled.

Published Reports

Report No. 1: Lawrence D. Haber, "Identifying the Disabled: Concepts and Methods in the Measurement of Disability," *Social Security Bulletin,* December 1967

Report No. 2: Lawrence D. Haber, "Disability, Work, and Income Maintenance: Prevalence of Disability, 1966," *Social Security Bulletin,* May 1968

Report No. 3: Lawrence D. Haber, "The Effect of Age and Disability on Access to Public Income-Maintenance Programs: 1966 Survey of Disabled Adults," Division of Disability Studies, ORS, SSA, July 1968

Report No. 4: Mildred E. Cinsky, "Health Insurance Coverage of the Disabled," Division of Disability Studies, ORS, SSA, August 1968

Report No. 5: Gertrude L. Stanley and Idella G. Swisher, "Medical Care Utilization of the Disabled," Division of Disability Studies, ORS, SSA, January 1969

Reports in Preparation

Lawrence D. Haber, *Major Disabling Conditions*
Idella G. Swisher, *Income of the Disabled*
Robert Cormier, *Medical Care Costs of the Disabled*

Table A (page 36) presents selected characteristics of disabled worker beneficiaries and childhood disability beneficiaries for: age at onset, race, marital status, veterans' status, education, region, diagnosis, functional limitations, work experience, current employment and occupation, employment and occupation at start of disability, and a measure of the adequacy of unit income. The table also includes data on severely disabled nonbeneficiaries.

table a
selected characteristics

table a./percent distribution of selected characteristics of the disabled population aged 18-64, spring, 1966, by sex

Selected Characteristics	Total Childhood Disability Beneficiaries			Total Disabled Worker Beneficiaries			Severely Disabled Nonbeneficiaries		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
Total number (in thousands)	*136*	*67*	*69*	*842*	*624*	*217*	*4475*	*1509*	*2966*
Age									
Total percent	100	100	100	100	100	100	100	100	100
18-21	7	10	4	..	..	..	3	5	2
22-24	8	8	7	..	..	..	3	4	2
25-34	29	33	25	2	2	3	9	7	9
35-44	32	32	32	8	8	9	21	17	24
45-54	21	12	30	27	26	28	27	27	27
55-64	4	5	2	63	64	60	37	41	35
Median Age	37	35	39	57	58	57	50	52	50
Age at initial onset of disability									
Total percent	100	100	100	100	100	100	100	100	100
Under 18	86	87	86	4	4	5	16	19	15
18-34	7	9	6	14	13	17	27	23	29
35-54	4	1	7	60	61	58	46	45	46
55-64	1	1	..	22	23	21	11	12	10
Not reported	1	1	2	*	*	..	1	1	1
Color									
Total percent	100	100	100	100	100	100	100	100	100
White	88	88	88	86	86	85	78	80	77
Nonwhite	11	12	12	14	14	15	22	20	23
Marital status									
Total percent	100	100	100	100	100	100	100	100	100
Married-spouse present	1	1	1	71	77	55	63	58	66

Widowed	1	0	2	8	5	19	8	3	11
Divorced, separated	..	0	1	11	10	15	13	12	14
Never married	98	99	97	9	8	12	15	27	9
Veteran status (men only)									
Total percent	..	100	..	..	100	..	..	100	..
Veteran	..	2	..	..	26	..	..	28	..
Nonveteran	..	99	..	..	74	..	..	72	..
Education									
Total percent	100	100	100	100	100	100	100	100	100
Less than 8 years	77	75	80	38	43	24	36	45	31
8 years	10	12	7	20	21	18	16	18	15
High school (1-3 yrs.)	4	3	4	19	16	26	20	14	23
High school (4 yrs.)	6	6	6	15	13	23	17	10	20
College	1	..	1	7	6	9	10	12	9
Not reported	2	3	2	*	..	..	1	1	1
Median number of years	2	2	1	8	8	10	8	8	9
Region									
Total percent	100	100	100	100	100	100	100	100	100
Northeast	21	18	23	22	20	28	18	13	20
Northcentral	30	31	29	22	22	24	24	23	24
South	40	40	42	40	43	33	42	47	40
West	8	10	6	15	15	15	16	16	16
Diagnosis									
Total percent	100	100	100	100	100	100	100	100	100
Infective and parasitic diseases	1	..	1	2	3	*	1	1	1
Neoplasms	..	..	..	2	2	3	3	3	3
Allergic	1	1	1	5	4	6	9	6	11
Mental	55	58	52	7	6	9	10	15	8
Diseases of the nervous system	21	18	23	18	18	17	9	10	9
Diseases of the sense organs	4	3	4	5	4	6	3	3	2

Selected Characteristics	Total Childhood Disability Beneficiaries			Total Disabled Worker Beneficiaries			Severely Disabled Nonbeneficiaries		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
Circulatory disorders	3	1	4	32	33	29	23	17	26
Respiratory disorders	..	..	..	8	9	6	3	5	2
Digestive system	..	..	..	2	2	2	6	6	6
Genito-urinary trouble	..	..	..	1	1	1	3	2	3
Bones and organs of movement	7	9	4	19	18	21	27	28	26
All others	8	7	9	1	1	1	2	3	2
Functional limitations									
Total percent	100	100	100	100	100	100	100	100	100
I—No loss	9	12	6	5	6	3	16	19	15
II—Minor loss	4	6	3	13	12	14	27	23	29
III—Moderate loss	7	10	4	19	22	12	19	20	18
IV—Severe loss	1	..	3	17	17	15	11	12	11
V—Functionally dependent	78	72	84	46	43	56	27	26	27
1965 Work experience									
Total percent	100	100	100	100	100	100	100	100	100
No work in 1965	90	84	97	85	82	93	62	49	69
Never employed	85	75	94	1	1	1	14	11	16
Not employed in 1965	6	9	3	84	81	91	48	38	53
Worked in 1965	9	15	3	11	13	4	35	47	28
Full-time all year (35 + hrs.—50 + wks.)	1	3	..	1	1	..	2	4	*
Full-time (26-49 weeks)	..	..	..	1	1	*	5	9	3
Part-time (26 weeks or more)	4	6	3	3	4	*	14	19	11
Intermittent (less than 26 weeks)	2	4	..	7	8	3	15	15	14

Current labor force									
Total percent	100	100	100	100	100	100	100	100	100
In labor force	10	15	3	7	8	2	23	35	17
Employed	8	13	3	6	7	2	20	30	15
Unemployed	1	1	1	1	1	*	3	6	2
Not in labor force	90	84	97	93	92	98	77	65	82
Current occupation									
Total number	*11*	*9*	*2*	*48*	*45*	*4*	*900*	*446*	*454*
Total percent	**	**	**	100	100	**	100	100	100
Professional and technical	..	..	..	4	4	..	4	3	6
Managers, officials, and proprietors	..	..	..	17	18	..	11	16	6
Clerical	..	..	..	6	7	..	4	2	6
Sales	..	..	..	6	4	..	7	4	9
Craftsmen and foremen	..	..	..	12	11	..	2	5	..
Operatives	..	..	..	17	16	..	11	16	6
Farm managers	..	..	..	10	11	..	7	11	3
Farm laborers	..	..	..	4	4	..	16	24	8
Private household	..	..	..	..	..	..	19	*	38
Service	..	..	..	12	13	..	12	5	19
Laborers	..	..	..	10	9	..	7	13	1
Not reported	..	..	..	2	2	..	..	..	..
Employment at start of disability									
Total number	*136*	*67*	*69*	*842*	*624*	*217*	*4475*	*1509*	*2966*
Total percent	100	100	100	100	100	100	100	100	100
Not employed before onset of disability	97	96	98	6	4	12	29	21	32
Employed before onset of disability	3	4	2	94	95	88	71	79	67

Selected Characteristics	Total Childhood Disability Beneficiaries			Total Disabled Worker Beneficiaries			Severely Disabled Nonbeneficiaries		
	Total	Men	Women	Total	Men	Women	Total	Men	Women
Employed in year of onset or last employed in year before onset	3	3	2	91	94	85	55	74	46
Last employed 2 or more years before onset	..	..	..	2	2	4	15	4	21
Not reported employment before onset	*	1	..	1	1	*	1	*	1
Occupation at start of disability									
Total number	*3*	*2*	*2*	*769*	*586*	*183*	*2465*	*1115*	*1350*
Total percent	**	**	**	100	100	100	100	100	100
Professional and technical	..	..	..	3	2	5	6	3	8
Managers, officials, and proprietors	..	..	..	6	7	4	5	7	3
Clerical	..	..	..	8	3	22	6	3	8
Sales	..	..	..	3	2	7	5	5	5
Craftsmen and foremen	..	..	..	22	28	2	9	18	1
Operatives	..	..	..	31	31	34	23	24	22
Farm managers	..	..	..	3	4	1	3	7	*
Farm laborers	..	..	..	3	3	*	5	4	6
Private household	..	..	..	2	..	7	11	1	19
Service	..	..	..	9	7	16	14	8	19
Laborers	..	..	..	9	11	1	7	14	*
Not reported	..	..	..	2	3	2	7	6	8

Adequacy of income [1]									
Total number of units [2] (in thousands)	*136*	*67*	*69*	*849*	*650*	*199*	*3478*	*1472*	*2006*
Total percent	100	100	100	100	100	100	100	100	100
0-50% of poverty index	80	78	84	14	15	12	41	44	38
51-75	14	15	12	20	19	25	14	18	11
76-90	2	3	1	9	10	8	5	5	5
91-100	1	1	1	6	6	5	3	3	3
101-110	*	..	*	4	4	2	2	3	2
111-125	2	2	1	6	7	3	4	5	4
126-150	..	..	..	9	9	11	6	5	6
151 or more	1	1	..	31	30	36	26	18	32
Median	32	32	30	103	101	109	68	60	80

[1] SSA Poverty Index: 1965 income received as percent of low cost budget standard.

[2] The disability unit consists of the disabled adult, a spouse if married, and any unmarried children under age 18.

* Less than 0.5 percent.
** Percentages not computed when population base is less than 25,000.

Percentages computed on rounded numbers.

The Social Security Survey of Disabled Adults: Technical Note

Under the old-age, survivors, disability, and health insurance (OASDHI) program, disability benefits are provided to severely disabled adults with extensive work experience in covered employment and to adults disabled since childhood who are dependents of retired, disabled, or deceased insured workers.

In 1966 the Social Security Administration undertook a major national study of disability. The study population includes all disabled adults aged 18-64 in the United States. The study has several objectives:

—to describe the prevalence, nature, and extent of work-limiting disability

—to examine the relationship of antecedent and onset factors to the severity of the disability and the subsequent work experience

—to examine the effect of the severity of the disability on income and income sources, occupation and work adjustments, medical care, rehabilitation, and family relationships and activities

—to examine the relationship of the public income-maintenance programs, in terms of the populations "selected by" or benefiting from the provisions of these programs—including, for example, comparison of the characteristics of disabled OASDHI beneficiaries, disabled adults receiving support from other income-maintenance programs, and disabled adults with no income from public income-maintenance programs

—to examine alternative program provisions for disability and work experience requirements.

Study Design

The study is being conducted through two surveys, a household survey for the noninstitutionalized population and an institutional survey. Field work for the survey of the noninstitutionalized adult population was carried out by the Bureau of the Census during the spring of 1966.

The Survey of Disabled Adults is based on a multiframe area probability sample design, selected to be representative of the noninstitutionalized civilian population aged 18-64 of the United States. The survey was conducted in two stages: first, to screen the population aged 18-64 for people with health-related limitations in their ability to work or do housework whose condition had lasted longer than 3 months; second, to verify the disability statement and to collect data on the nature, severity, onset, and duration of the disability, current and past labor-force status and work experience, medical care, rehabilitation services, income and income sources, assets, family relationships and activities, and demographic characteristics. The first stage was conducted by mail questionnaire. The second stage was conducted by interview. The Bureau of the Census was responsible for data collection and processing.

The survey sample was selected from a 243 first-stage area design, combining the Census Bureau's Monthly Labor Survey (MLS) and

Current Population Survey (CPS) primary sampling units. Approximately 30,000 households were selected from seven population frames, including 18,000 sample households from the CPS and MLS, 2,000 OASDHI disability beneficiaries, 1,700 persons receiving public assistance because of disability, and 8,000 persons whose application for OASDHI disability benefits has been denied or disallowed.

The disability identification questionnaires were mailed out during February-March 1966. There were two certified mail follow-ups for nonresponses and personal interview callbacks for a subsample of the remaining nonresponses. A subsample of disabled persons stratified by extent of limitations was selected for interview. The completed survey sample includes approximately 8,700 disabled adults who were interviewed by Census enumerators during April-May 1966.

Survey Definition of Disability

Disability is defined in this study as a limitation in the kind or amount of work (or housework) resulting from a chronic health condition or impairment lasting 3 or more months. The extent of incapacity ranges from inability to perform any kind of work to secondary limitations in the kind or amount of work performed. The disability classification is based on the extent of the individual's capacity for work, as reported by the respondent in a set of work-qualification questions. Data on employment and on functional capacities—such as mobility, activities of daily living, personal care needs, and functional activity limitations—were also collected to evaluate the nature and severity of the disability.

The severity of the disability was classified by the extent of the work limitations:

- ☐ Severely disabled—unable to work altogether or unable to work regularly.
- ☐ Occupationally disabled—able to work regularly, but unable to do the same work as before the onset of disability or unable to work full time.
- ☐ Secondary work limitations—able to work full time, regularly and at the same work, but with limitations in the kind or amount of work they can perform; women with limitations in keeping house, but not in work are included among those with secondary work limitations.

Reliability of the Estimates

Since the estimates in this report are based on a sample, they may differ somewhat from the figures that would have been obtained if all disabled adults in the United States had been surveyed using the same schedules, instructions, and interviewers. As in any survey work, the results are subject to error of response and reporting as well as to sampling variability. The standard error is primarily a measure of sampling variability, i.e., the variations that occur by chance because a sample rather than a whole population is measured. As calculated for this report, the standard error also partially includes the effect of

response variation but does not measure systematic biases in the data. The chances are about 68 out of 100 that an estimate from the sample would differ from a complete census figure by less than the standard error. The chances are about 95 out of 100 that the difference would be less than twice the standard error.

Sampling Variability

Rough approximations of the sampling variability of some selected figures have been prepared to provide a general indication of the order of magnitude of the sampling variability for the estimated numbers and percentages presented in this report. A tabulation and estimation program is being developed to provide, at moderate cost, a set of standard errors that will be applicable to a wide variety of items. Both the rough approximations shown in the reports listed above and the additional work now in progress involve a number of simplifying assumptions. Thus, these standard errors provide an indication of the order of magnitude rather than the precise standard error for a specific item.

NOTE:
The population studied includes all persons aged 18-64 in the civilian noninstitutional population in March 1966. Estimates of the U.S. civilian noninstitutional population were obtained from special tabulations of the February-March Current Population Survey, the *Current Population Reports* of the Bureau of the Census, and the *Special Labor Force Reports* of the Bureau of Labor Statistics. Data on the civilian noninstitutionalized disabled population aged 18-64 were obtained from the 1966 Survey of Disabled Adults. Estimates of the nondisabled population were obtained by subtracting the disabled population from the U.S. population. The disabled population includes adults disabled for longer than 6 months.

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